Respiratory syncytial virus (RSV) infections in paediatric transplant patients

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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR RESPIRATORY SYNCYTIAL VIRUS (RSV) INFECTIONS IN PAEDIATRIC TRANSPLANT PATIENTS

Report all inpatients and outpatients less than 18 years of age who have:

- a laboratory-confirmed respiratory syncytial virus (RSV) infection
  and
- received a solid organ transplantation (SOT) or a haematopoietic stem cell transplantation (HSCT) within the two previous years.

Month first seen _____

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: _____ /_____ /_____ (DD / MM / YYYY) 1.2 Sex: Male ___ Female ___

1.3 Gestational age: term ___ prematurity ___ specify: ____ weeks unknown ___

1.4 Ethnicity: First Nations ___ Innu ___ Inuit ___ Métis ___ Asian ___ Black ___ Caucasian ___
Latin American ___ Middle Eastern ___ Other (specify): _____ Unknown ___

1.5 Province/Territory of residence: _____
Urban ___ Rural (population <1,000) ___ Unknown ___

1.6 Total number of children in the home (excluding patient) _____ Unknown ___

1.7 Number of children ≤5 years of age in the home (excluding patient) _____ Unknown ___

1.8 Does a household member smoke:	**Yes**	**No**	**Unknown**
in the house?	___	___	___
in the automobile?	___	___	___

1.9 Does patient attend day care or home care with ≥4 children (including patient)? ___ ___ ___

SECTION 2 – PAST HISTORY

2.1 Does the child have any type of chronic lung disease? ___ ___ ___
If yes, specify: Chronic lung disease of prematurity requiring medical therapy in the preceding 6 months ___
Other lung disease requiring chronic oxygen in the preceding 6 months ___ CF ___
Other (specify type): _____

SECTION 2 – PAST HISTORY (cont'd)

		Yes	No	Unknown
2.2	Has this child had a tracheostomy in the preceding 12 months?	___	___	___
2.3	Does the child have:			
2.3.1	hemodynamically significant heart disease post-transplant?	___	___	___
2.3.2	Down syndrome?	___	___	___
2.3.3	evidence for pulmonary aspiration in the year prior to RSV infection?	___	___	___
2.3.4	a neurologic condition with a risk for aspiration?	___	___	___

SECTION 3 – TRANSPLANTATION AND TREATMENT

3.1 Date of transplant (if more than one, specify most recent date): ____ /____ /_____
DD MM YYYY

3.2 Type of transplant: liver ___ kidney ___ heart ___ lung ___ small bowel ___
multiple organs, specify: _____
autologous HSCT ___ allogeneic HSCT ___

		Yes	No	Unknown
3.3	Did the child receive induction anti-lymphocyte therapy?			
	• antilymphocyte globulin (Thymoglobulin®)	___	___	___
	• muromonab-CD3 (OKT3®)	___	___	___
	• basiliximab (Simulect®)	___	___	___
	• daclizumab (Zenaprex®)	___	___	___
3.4	Has the child been treated for rejection?	___	___	___
	If yes, specify date of last treatment: ____ /____ /_____ DD MM YYYY			
3.5	Does the child have evidence for Graft Versus Host Disease (GVHD)?	___	___	___

SECTION 4 – RSV PRESENTATION AND TREATMENT

4.1 Date of RSV diagnosis: ____ /____ /_____ Inpatient ___ Outpatient ___
DD MM YYYY

4.2	Did the child have a lower respiratory tract infection? (defined as need for oxygen or increased oxygen, wheezing, crepitations, or CXR changes)	___	___	___
4.3	Was the RSV infection nosocomial?	___	___	___
4.3.1	Symptoms starting in hospital >2 days after admission	___	___	___
4.3.2	Symptoms starting at home <2 days of hospital discharge	___	___	___
4.4	Was the child admitted because of RSV?	___	___	___
	If yes, number of days in hospital: _____			
4.5	Was the child admitted to ICU because of RSV?	___	___	___
	If yes, number of days: _____			
4.6	Was the child already in ICU for other reasons?	___	___	___
	If yes, number of days in ICU due to RSV: _____			
4.7	Was the child ventilated because of RSV?	___	___	___
	If yes, number of days: _____			
4.8	Did the child require ECMO (ECLS) because of RSV?	___	___	___
	If yes, number of days: _____			

SECTION 4 – RSV PRESENTATION AND TREATMENT (cont'd)

		Yes	No	Unknown
4.9	Did the child receive intravenous immunoglobulin (IVIG) as treatment of RSV?	___	___	___
4.10	Did the child receive palivizumab as treatment for RSV?	___	___	___
4.11	Did the child receive ribavirin as therapy for RSV?	___	___	___

If yes, provide route and duration: _____

4.12 Current immunosuppression at time of RSV (check all that apply):

Tacrolimus/FK-506 ___ Cyclosporin A (Sandimmune®, Neoral®) ___

Mycophenolate mofetil/MMF ___ Azathioprine ___ Sirolimus/rapamycin ___

Steroids ___ specify dose, mg/kg/day: _____ dose unknown ___

Others, specify drug names: _____

SECTION 5 – MANAGEMENT

5.1	Was palivizumab recommended post transplant for this patient?	___	___	___
	If yes, specify: for the current RSV season	___	___	___
	only for the preceding RSV season	___	___	___
5.2	Did this patient receive palivizumab within 4 weeks prior to RSV diagnosis?	___	___	___
	If yes, specify date of last dose: ____ /____ /_____ (DD MM YYYY)			
5.3	Was the transplant centre made aware of the RSV infection?	___	___	___

SECTION 6 – OUTCOME

6.1	Patient still in hospital:	___	___	___
6.1.1	Patient transferred to another facility:	___	___	___
	If yes, please specify: _____			
6.3	Patient discharged home:	___	___	___

If yes, with no short-term sequelae from RSV ___

with home oxygen due to RSV ___

with other RSV-related sequelae at discharge; specify:

_____

6.4	Patient is deceased	___	___	___

If yes, age at time of death: _____ weeks / months

If yes, cause of death during admission:

6.4.1 RSV infection ___

6.4.2 RSV contributing to death but not the primary cause ___

6.4.3 RSV did not contribute to death ___

6.4.4 Other cause, specify: _____

6.5 Lost to follow-up ___

___ **I agree to be contacted by the research team for further information.**

___ **I do not wish to be contacted by the research team for further information.**

(over)

SECTION 7 – REPORTING PHYSICIAN

First name_____ Surname_____

Address_____

City_____ Province_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.

(RSV 2010-09)